



**Muscokee (Creek) Nation  
Human Services Department  
Social Services Office  
Tribal Burial Application**

Yes, I would like Food for Funeral  
No, I do not need Food for Funeral

Please complete with the deceased's information:

Deceased Name		DOB		Social Security #		Roll #	
Address		City		State		Zip	
Marital Status:	Single	Married	Separated	Divorced	Widow/er		
Employment Status:	Unemployed						
	Employed		Full-time	Part-time			
	1 <sup>st</sup> Employer: _____						
	Last day worked: _____						
	2 <sup>nd</sup> Employer: _____						
	Last day worked: _____						

Did the deceased have minor children?      Yes      No      If yes, refer to MCN Social Services Office

Did the deceased have a spouse?      Yes      No      If yes, refer to MCN Social Services Office

Was the deceased receiving SSA, SSI, or SSDI?      Yes      No

Was the deceased a Veteran?      Yes      No

If yes, was the deceased receiving compensation or pension payment from the V.A.?      Yes      No

**FUNERAL SERVICE INFORMATION**

Date of Death: \_\_\_\_\_

Funeral Home: \_\_\_\_\_

Wake Service:    When \_\_\_\_\_ Where \_\_\_\_\_ Time \_\_\_\_\_

Funeral:          When \_\_\_\_\_ Where \_\_\_\_\_ Time \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

(Person who signs the burial contract with the funeral home.)

Name: \_\_\_\_\_ Relation to deceased: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

**AUTHORIZED PERSON INFORMATION (if applicable)**

(Person who has written permission from the responsible party to complete the application and/or pick up the food voucher.)

Name: \_\_\_\_\_ Relation to Responsible Party: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

**Fair Hearing Statement:**

Once the Social Services Office is in receipt of your application, it will be considered pending until all documentation required is received or up to 20 days, whichever comes first. After 20 days your application will be denied. **ALL documentation required must be received in order for eligibility to be determined.** If you feel the decision of the Social Services Staff is in error, you may file a written appeal within 20 days after receiving a letter of denial to the Manager of the Human Services Department. The Human Services Manager will review and make a decision regarding your appeal within ten (10) days after receiving your written appeal. If the Human Services Manager upholds the initial decision, you have ten (10) days after receiving their written decision to file a written appeal to the Secretary of the Department of Community and Human Services.

**Privacy Act Statement:**

Muscogee (Creek) Nation Social Services Office cannot give out your information, except Social Services can share the information with other Federal, State, Tribal offices, programs and/or businesses who have some responsibility with the services for which you are applying. For any other person or program wanting information from your case file, you must first give your consent. You have a right to know what information is in your case record and you can ask to see it if you believe some information in your case file is inaccurate, ask your social worker about how to change the information in your case file.

**Fraud:**

All information pertinent to services requested is subject to verification. This includes, but not limited to, landlords, mortgage companies, utility companies, employer, funeral homes, etc. Falsification of this information shall be grounds for 1) denial of this application, 2) not eligible to receive assistance for six (6) months up to a year, 3) all parties, agencies, tribes, etc. will be notified, and 4) may be forwarded to the Attorney General's Office if further action is needed.

**Certification:**

By signing below, I certify I have read this application or had this application read to me and that all information provided by me, oral and written, is true and accurate. I also acknowledge I have read and understand the Fair Hearing Statement, Privacy Act Statement, and Fraud Statement.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Person (If applicable)

\_\_\_\_\_  
Date

\*\*\*\*\*

**OFFICE USE ONLY**

**Date Application Received:**

**Date Application Assigned:** \_\_\_\_\_

**Social Worker Assigned to:** \_\_\_\_\_

\_\_\_\_\_ **Application Approved**    **Amount:** \_\_\_\_\_

\_\_\_\_\_ **Application Denied**    **Reason for denial:** \_\_\_\_\_

\_\_\_\_\_  
Social Worker Signature

\_\_\_\_\_  
Date Completed



**Muscogee (Creek) Nation  
Human Services Department  
Release of Information**

You grant and authorize the exchange of information between the BIA/Tribal Human Services Department and the following agencies/programs:

Tribal/State Employment Offices  
Tribal State Social Services  
Social Security Administration  
Tribal/State Education Programs  
Tribal/State/Federal Courts  
Tribal/State Medical Services  
Tribal Enterprises  
Alaska Native Corporations  
State/Country Fiduciary Trust Offices

Tribal/State Alcohol & Drug Programs  
Tribal/State Housing Programs  
Veteran's Administration  
Tribal/State Federal Probation Programs  
Tribal/State Child Protection Services  
Tribal/State Mental Health Services  
Tribal/State Voc-Rehab Programs  
Indian Health Services

Other (specify): \_\_\_\_\_

Other (specify): \_\_\_\_\_

Other (specify): \_\_\_\_\_

Any information exchanged will pertain to your eligibility to receive Financial Assistance and Social Services benefits or referral to other programs that would benefit you. By signing the Certification on the application you agree and understand any information obtained will be kept confidential and will be used only for the purposes directly connected with providing benefits or services on your behalf. You further agree and understand that any information obtained may be released to proper governmental agency, court, or law enforcement agencies for purposes of legal and investigative action concerning fraud.

This Release of Information will remain in effect for one (1) year from date of signature or until you request to rescind authorization.

I authorize the Human Services Department to obtain and/or exchange information necessary to establish eligibility for Financial Assistance and Social Services.

\_\_\_\_\_  
Applicant Name (Print)

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date